## CHECK LIST FOR GROUP PROVIDER REVALIDATION

- 1. B SINGLE SIGN ON(SSO) NAME AND PASSWORD
- 2. B CHAMPS PROVIDER APPLICATION NOTIFICATION NUMBER
- 3. R National Provider Identifier (NPI)
- 4. ® Address Information
- 5. **®** Federal Tax ID Number (EIN/TIN)
- 6. ® Ownership Information and Ownership in other Medicare/Medicaid Entities
  - a. Names
  - b. SS#/EIN/TIN#
  - c. Owners Phone Number
  - d. Owners Address
  - e. Percentage of ownership 5% or greater
  - f. Relationship
  - g. Associated Dates
  - h. Owner Type
    - i. Individual/Sole Proprietor
    - ii. Partnership
    - iii. Corporate
    - iv. Corporate-Charitable 501[c]3
    - v. Corporate-Non Charitable
    - vi. Government
    - vii. Foreign, Nonresident Alien
- 7. Provider Specialty/Subspecialty Information
- 8. ® Taxonomy Code
  - a. Start Date
- 9. R Phone Number
- 10. **®** Accept 835
- 11. Billing Agent ID
  - a. Association Start and End Date
- 12. Managing Employee
  - a. Name
  - b. Social Security Number
- 13. Entity Business Name (DBA)
- 14. Fax Number
- 15. Email Address
- 16. Web Page
- 17. Office Hours
- 18. Handicap Accessible
- 19. Communication Preference
- 20. Language Spoken
- 21. Mode of Claim Submission
  - a. Data Exchange Gateway (DEG)
  - b. Electronic Batch
  - c. Billing Agent
  - d. Direct Data Entry
  - e. Paper
- 22. Questions:
  - a. Have you ever had a Program Exclusion/Debarment?

- b. Have you ever had a Criminal or Health Related Conviction?
- c. Have you ever had a Judgment Under any False Claims Act?
- d. Have you ever had a Civil Monetary Penalty?
- e. Do you need to request a Retro Enrollment Date? If so, what date are you requesting?
- f. Has this location been approved as a Family Planning Clinic or Maternal & Infant Support? If so, date of approval.
- g. Is your W-9 current on Vendor Registration? If not please go to www.cpexpress.state.mi.us
- h. If you are using a Billing Agent, has the Billing Agent been approved?
- i. **®**Are you accepting new clients?

## ® REQUIRED INFORMATION